STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-0258

September 19, 2000

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Public Health Directors
All County Mental Health Directors

Letter No.: 00-47

UPDATED CAMERA-READY COPY OF THE UNEMPLOYED PARENT DETERMINATION WORK SHEET AND VOCATIONAL AND WORK HISTORY (MC 210) AND THE MEDICAL REPORT FORM (MC 61)

Ref: All County Welfare Directors Letter (ACWDL) Nos. 97-17, 97-26, 97-37, 99-54, and 99-76

This letter is to inform you of changes on two forms that the county uses to determine the principal wage earner (PWE) when establishing deprivation as an unemployed parent and to establish incapacity.

The MC 210 S-W has been changed to incorporate March 1, 2000 changes in state law (Assembly Bill 1107, Chapter 146, Statutes of 1999) which allow the PWE to work over 100 hours if the family's net nonexempt earned income is not more than 100 percent of the federal poverty level.

The California Work Opportunity and Responsibility to Kids (CalWORKs)program is revising the CA 61 to delete certain questions and will include questions that will allow counties to determine if the individual is able to pursue employment for CalWORKs persons despite their incapacity. Since we wanted to continue using the same questions, we have renamed it (MC 61) and slightly modified the format.

If you have any further questions, please contact Ms. Margie Buzdas at (916) 657-0726 or Ms. Erin Lynch at (916) 654-5769

ORIGINAL SIGNED BY

Glenda Arellano, Acting Chief
Medi-Cal Eligibility Branch

Enclosures

State of California—Health and Human Services Agency

Department of Health Services

MEDICAL REPORT

COUNTY USE ONLY

Case name	Case number	Worker name	Worker number

SECTION I: PATIENT/CLIENT INFORMATION AND MEDICAL RELEASE

Name of patient/client (last, first, middle) / *Nombre del paciente/cliente (apellido, primer nombre, segundo nombre)*

Birth date / *Fecha de nacimiento*	Social Security number / *Número del Seguro Social*	Sex / *Sexo* ☐ Male/masculino ☐ Female/femenino	Ages of children in home / *Edades de los niños en el hogar*

I authorize / *Autorizo a* _____ of / *de* _____

Name of licensed physician or certified psychologist
Nombre del doctor con licencia o psicologo certificado

Name of clinic or medical group
Nombre de la clínica o grupo médico

to release my medical information on this form to the county welfare department. This authorization is valid for one year from the date signed and I may ask for a copy of this authorization.

para que proporcione al departamento de bienestar público del condado. La información médica que se solicita en este formulario. Esta autorización es válida por un año a partir de la fecha de la firma y tengo derecho a solicitar una copia de esta autorización.

Patient/client signature / *Firma del paciente/cliente*	Date/*Fecha*
➤	

SECTION II: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST INSTRUCTIONS AND CERTIFICATION

The county welfare department needs your information to determine if the above-named person has a physical or mental incapacity that prevents or substantially reduces the patient's ability to engage in full-time work, training, and/or provide necessary care for his/her child(ren).

Please complete the rest of this form. Explain if you need additional lab work or other exam(s) before you can determine the duration of incapacity. If you need more space, use another sheet of paper and attach it to this form.

PLEASE GIVE THIS FORM TO THE PATIENT OR RETURN IT AND/OR OTHER VERIFICATION WITHIN FIVE WORKING DAYS TO:

(County Stamp)

1. Does the patient have a physical or mental incapacity that prevents or substantially reduces his/her ability to work full time at his/her customary job?
   - ☐ Yes If yes, expected duration: _____
     - ☐ Temporary, expect to release patient for full-time work on _____ (month, day, year)
     - ☐ Permanent
   - ☐ No
2. Does the patient have a physical or mental incapacity that prevents or substantially reduces his/her abililty to care for his/her children?
   - ☐ Yes If yes, expected duration: _____
     - ☐ Temporary, expect to release patient for full-time work on _____ (month, day, year)
     - ☐ Permanent
   - ☐ No
3. List DIAGNOSIS and PROGNOSIS for this patient:

   _____

   _____

   _____
4. Onset date: _____ (month, day, year)

- I understand that the statements I have made on this form are subject to verification and investigation for welfare fraud.
- I declare under penalty of perjury under the laws of the United States and the State of California that the information contained in this report is true, correct, and complete.

Signature of physician, licensed certified psychologist, or person authorized to complete form	Date
➤	
Printed name and title/specialty	Phone number ( )

Street address *(mailing address, if different)*	City	State	ZIP code

VOCATIONAL AND WORK HISTORY
(To Be Completed By Applicant/Beneficiary)

Parent Number 1 Name: _____

List your employment and training history for the last two years. Begin with your current or latest job or training.

Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly	Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly
1.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	4.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
2.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	5.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
3.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	6.	☐ Work ☐ Training	From __/__/__ To __/__/__	$

Parent Number 2 Name: _____

List your employment and training history for the last two years. Begin with your current or latest job or training.

Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly	Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly
1.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	4.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
2.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	5.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
3.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	6.	☐ Work ☐ Training	From __/__/__ To __/__/__	$

MEDI-CAL U-PARENT DETERMINATION WORKSHEET
(To Be Completed By CWD Staff)

Case name:_____ Worker number:_____

Case number: _____ Date: _____

1. Determination of Principal Wage Earner **(PWE)**

   a. Application date OR date U-Parent deprivation began: _____
   b. To establish 24-month earnings period, check month on chart for each parent:

   Month number 1: subtract two years from line (a): _____

   Month number 24: Month/Year immediately preceding line (a): _____

Parent 1's Earnings

_____
Name

Total: $_____

Current year _____		Year _____		Year _____	
$	Dec.	$	Dec.	$	Dec.
$	Nov.	$	Nov.	$	Nov.
$	Oct.	$	Oct.	$	Oct.
$	Sep.	$	Sep.	$	Sep.
$	Aug.	$	Aug.	$	Aug.
$	Jul.	$	Jul.	$	Jul.
$	Jun.	$	Jun.	$	Jun.
$	May	$	May	$	May
$	Apr.	$	Apr.	$	Apr.
$	Mar.	$	Mar.	$	Mar.
$	Feb.	$	Feb.	$	Feb.
$	Jan.	$	Jan.	$	Jan.

Parent 2's Earnings

_____
Name

Total: $_____

Current year _____		Year _____		Year _____	
$	Dec.	$	Dec.	$	Dec.
$	Nov.	$	Nov.	$	Nov.
$	Oct.	$	Oct.	$	Oct.
$	Sep.	$	Sep.	$	Sep.
$	Aug.	$	Aug.	$	Aug.
$	Jul.	$	Jul.	$	Jul.
$	Jun.	$	Jun.	$	Jun.
$	May	$	May	$	May
$	Apr.	$	Apr.	$	Apr.
$	Mar.	$	Mar.	$	Mar.
$	Feb.	$	Feb.	$	Feb.
$	Jan.	$	Jan.	$	Jan.

The parent earning the greater amount is the PWE: _____
(Name of PWE)

2. Is the PWE working 100 hours or more a month? ☐ Yes ☐ No
   If "yes," complete the Unemployed Parent Worksheet (MC 337).

Note: If the PWE is a recipient of Section 1931(b), he/she may exceed 100 hours with no earned income test.

VOCATIONAL AND WORK HISTORY/*HISTORIAL VOCACIONAL Y LABORAL*

(To Be Completed By Applicant/Beneficiary/*Para que el solicitante/beneficiario lo complete*)

Parent Number 1/Padre/*Madre Número 1* Name/*Nombre*: _____

List your employment and training history for the last two years. Begin with your current or latest job or training. ***Anote su historial de empleo y capacitación durante los últimos dos años. Comience con su empleo o capacitación actual o más reciente.***

Name of Employer or Training Program/*Nombre del Empleador o Programa de Capacitación*	Work or Training/ *Trabajo o Capacitación*	When Employed/ *Cuándo se le Empleó*	Gross Amount Monthly/ *Cantidad Mensual Bruta*	Name of Employer or Training Program/*Nombre del Empleador o Programa de Capacitación*	Work or Training/ *Trabajo o Capacitación*	When Employed/ *Cuándo se le Empleó*	Gross Amount Monthly/ *Cantidad Mensual Bruta*
1.	☐ Trabajo ☐ Capacitación	Del ___/___/___ Al ___/___/___	$	4.	☐ Trabajo ☐ Capacitación	Del ___/___/___ Al ___/___/___	$
2.	☐ Trabajo ☐ Capacitación	Del ___/___/___ Al ___/___/___	$	5.	☐ Trabajo ☐ Capacitación	Del ___/___/___ Al ___/___/___	$
3.	☐ Trabajo ☐ Capacitación	Del ___/___/___ Al ___/___/___	$	6.	☐ Trabajo ☐ Capacitación	Del ___/___/___ Al ___/___/___	$

Parent Number 2/Padre/*Madre Número 2* Name/*Nombre:* _____

List your employment and training history for the last two years. Begin with your current or latest job or training. ***Anote su historial de empleo y capacitación durante los últimos dos años. Comience con su empleo o capacitación actual o más reciente.***

Name of Employer or Training Program/*Nombre del Empleador o Programa de Capacitación*	Work or Training/ *Trabajo o Capacitación*	When Employed/ *Cuándo se le Empleó*	Gross Amount Monthly/ *Cantidad Mensual Bruta*	Name of Employer or Training Program/*Nombre del Empleador o Programa de Capacitación*	Work or Training/ *Trabajo o Capacitación*	When Employed/ *Cuándo se le Empleó*	Gross Amount Monthly/ *Cantidad Mensual Bruta*
1.	☐ Work ☐ Capacitación	Del ___/___/___ Al ___/___/___	$	4.	☐ Trabajo ☐ Capacitación	Del ___/___/___ Al ___/___/___	$
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   Month number 24: Month/Year immediately preceding line (a): _____

Parent 1's Earnings	Current year _____		Year _____		Year _____	
	$	Dec.	$	Dec.	$	Dec.
	$	Nov.	$	Nov.	$	Nov.
	$	Oct.	$	Oct.	$	Oct.
_____	$	Sep.	$	Sep.	$	Sep.
Name	$	Aug.	$	Aug.	$	Aug.
	$	Jul.	$	Jul.	$	Jul.
	$	Jun.	$	Jun.	$	Jun.
	$	May	$	May	$	May
	$	Apr.	$	Apr.	$	Apr.
	$	Mar.	$	Mar.	$	Mar.
Total: $_____	$	Feb.	$	Feb.	$	Feb.
	$	Jan.	$	Jan.	$	Jan.

Parent 2's Earnings	Current year _____		Year _____		Year _____	
	$	Dec.	$	Dec.	$	Dec.
	$	Nov.	$	Nov.	$	Nov.
	$	Oct.	$	Oct.	$	Oct.
_____	$	Sep.	$	Sep.	$	Sep.
Name	$	Aug.	$	Aug.	$	Aug.
	$	Jul.	$	Jul.	$	Jul.
	$	Jun.	$	Jun.	$	Jun.
	$	May	$	May	$	May
	$	Apr.	$	Apr.	$	Apr.
	$	Mar.	$	Mar.	$	Mar.
Total: $_____	$	Feb.	$	Feb.	$	Feb.
	$	Jan.	$	Jan.	$	Jan.

The parent earning the greater amount is the PWE: _____
(Name of PWE)

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